Bronze bas-relief plaque of the late Fitch C. E. Mattison: Unveiled and placed in the library of the Los Angeles County Medical Association on May 13, 1937

late Dr. Stanley P. Black, one-time professor of pathology of the College of Medicine of the University of Southern California, and the late Luther M. Powers, for a long period health officer of Los Angeles, and Dr. George H. Kress. Doctor Mattison and Doctor Kress officiated, respectively, as chairman and secretary of the Certified Milk Commission for more than twenty-five years, and this Certified Milk Commission has donated to the Los Angeles County Medical Association for certain purposes, moneys to the amount of some $20,000.

The Board of Trustees of the Los Angeles County Medical Association, through Dr. Donald C. Frick, Chairman, presented the plaque to the Library Committee, of which Dr. George Dock is chairman.

The plaque was then unveiled by Doctor Mattison's daughter, Mrs. Bess M. Behr. The main address of the evening was by Paul Popenoe, Ph.D., whose topic was, "Perpetuation of the Traditions of Medicine." Other talks were given by Miss Maud Daggett, the sculptress of the plaque; by Dr. George H. Kress, who spoke of the early days and experiences of the Certified Milk Commission; by Dr. Leroy B. Sherry, on "Pasadena's Tribute to a Beloved Son," and by Dr. Harlan Shoemaker, who referred to the great services which the Certified Milk Commission had rendered to the citizens of Southern California.

CLINICAL NOTES AND CASE REPORTS

NORMAL PREGNANCIES AND DELIVERIES IN BICORNATE UTERI*

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ALTHOUGH bicornate uteri have been known to exist for several centuries, it was not until a few decades ago that interest was aroused in the occurrence of pregnancy in these malformed uteri. It was Mauriceau and Vassal[1] who, in 1669, recorded the first case of pregnancy in a rudimentary horn of a bicornate uterus. It was not until the beginning of the twentieth century, however, that interest in this condition again came to light, although occasional cases were reported before this. An excellent review of the subject was made by Van der Velde[2] in 1915, and in 1922 Miller[3] collected fifty-four cases of uterus didelphys. In this series there were sixty-seven pregnancies, of which 61 per cent went to term. His studies included only those cases of separate uterus and cervix, and not the bicornate types (uterus bicornis, unicollis, septus, etc.) In reviewing the literature from 1922 to the present writing (July, 1936), we have found reports of 246 cases of malformations of the uterus, including double uterus and cervix (uterus didelphys), double fundus and one cervix, and uteri with rudimentary horns. There are, no doubt, others which we have missed.† Due to the incompleteness of many of the reports, it was not possible accurately to determine the number of pregnancies which occurred or the percentage of which went to term. However, it did appear that the number of pregnancies and percentage of these that went to term would be about the same as reported by Miller; yet it is possible there may have been a larger per cent of spontaneous abortions in this series.

From the foregoing it is evident that pregnancy in bicornate uteri is not rare; on the contrary, every physician doing a gynecologic and obstetrical practice must keep it in mind in every patient he sees. It is because of this and of our blunders in two such cases that we here present two cases of bicornate uteri.

REPORT OF CASES

Case 1.—Mrs. M. T., a Mexican, age twenty-three years, entered the San Bernardino County Charity Hospital on November 12, 1935, complaining of intermittent

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* From the department of surgery of the San Bernardino County Charity Hospital, San Bernardino.

1 Mauriceau and Vassal (1669): Quoted by Delée, Joseph B. The Principles and Practice of Obstetrics, p. 560, 1933. W. B. Saunders Company, Philadelphia.

2 Van der Velde, Geburtsstörungen durch: Entwicklungsfehler der Gebärmutter, Monatschr. f. Geburtsch. u. Gynäk. Berl. 42: 307-321, 1915.

3 Miller: Clinical Aspects of Uterus Didelphys, Am. J. Obst. and Gynec., 4: 398-408, St. Louis, 1922.

† The literature has become so voluminous and cumbersome we have not attempted to include a complete bibliography in this contribution.

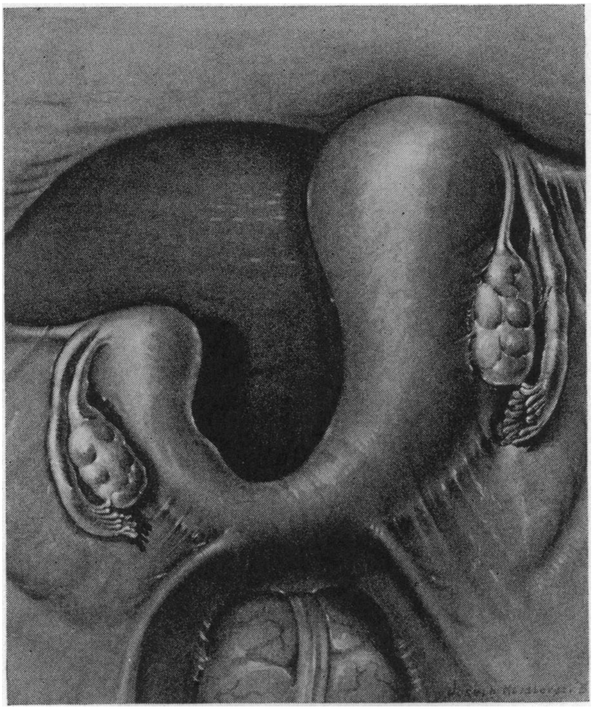

Fig. 1.—Drawing of bicornate uterus (Case 1).

vaginal bleeding, beginning ten days previous, when she passed what she thought was a fetus. Her last period was normal on September 25, 1935. She had had frequency, urgency, and burning on urination six weeks prior to this, with a persistent, moderate vaginal discharge since then. She had given birth to three children, of six, four, and three years, respectively, who are now living and well. Each delivery was normal, and the siblings weighed from six to seven and one-half pounds at birth. Examination of the patient revealed a well-developed Mexican female. There was no vaginal bleeding, but there was a tender, somewhat fluctuant mass, measuring about 8 by 4 by 3 centimeters, in the right adnexal region. The fundus of the uterus was palpable just to the left of the midline; it was about normal in size. Because of the presence of a mass, together with a mild leukocytosis and elevated temperature and pulse rate, a diagnosis of tubo-ovarian abscess was made. On November 22, 1935, a laparotomy was performed and a bicornate uterus was found. The two fundi were united at the cervix, but were otherwise separate. The right fundus measured about 11 centimeters from its fusion with its mate at the cervix to the top, and was about 7 centimeters wide at its greatest diameter. This uterus was the mass we had mistaken for a tubo-ovarian abscess, and was obviously subinvoluted. The other corpus was small and of nearly normal size, measuring 5 by 3 by 2½ centimeters. On the lateral aspect of each were broad and round ligaments, fallopian tubes, and ovaries. The round ligament on the right was about three or four times the diameter of that on the left, the latter of which was approximately of average normal size. The space between the fundi received a portion of the urinary bladder. The patient was sterilized at her request, and the abdomen was closed. She had an uneventful post-operative recovery. Diagnosis: Bicornate uterus with normal adnexa and incomplete involution of the right corpus following a complete abortion.

CASE 2.—Mrs. M. R., age thirty-one, entered the San Bernardino County Charity Hospital on January 12, 1936, complaining of pain of ten to twelve years' duration in the left lower quadrant, but much worse for two weeks, and accompanied by moderate vaginal bleeding. Prior to this her periods had been regular and the patient was sure she was not pregnant. Her menarche was at the age of thirteen years, with subsequent and normal periods except for an occasional dysmenorrhea. She has one living child, a thirteen-year-old girl who apparently is normal. Pelvic examination revealed only mild bleeding from the uterus, with a "sense of fullness in the left adnexal region with bilateral tenderness." It was thought that she might have either an ectopic pregnancy or a pelvic cellulitis. A laparotomy was performed on January 15, at which time a ruptured ectopic pregnancy was found in the left fallopian tube. The uterus was bicornate, the one on the left being a little larger than the normal nonpregnant uterus with only one tube. Blood-clots surrounded the distended tube and hemorrhagic ovary. The tube contained the products of conception of about a six weeks' gestation. The corpus on the right measured about 3 centimeters in its greatest transverse and anteroposterior diameters by 6 centimeters long. On the *anterosuperior* aspect of it were two pieces of what appeared to be ovarian tissue, the upper one measuring about 1.5 by 1 by 1 centimeter and the lower one about 1 centimeter in diameter. There was an apparently normal, average-size ovary on the right side, lying in the fossa ovarica. The fallopian tube on the right side appeared about average size and of normal consistency. These two corpi joined at a common cervix, the latter being about 2.5 centimeters long. The left tube and ovary were removed, and the right tube was crushed and ligated. The patient had an uneventful recovery, and has had no return of her pelvic complaints. Diagnosis: Bicornate uterus and ruptured left ectopic tubal gestation.

COMMENT

Our first case represents an easy mistake to make. Where there is a suggestive history of gonorrhea followed by menorrhagia, and in a pelvic examination a mass is felt in one adnexal region, one is prone to jump to the easier and more common diagnosis of a tubo-ovarian pathologic condition. However, it is of interest to note that this patient had had three normal pregnancies with spontaneous deliveries at term. The course of the second case is a fairly common one in such anomalies. Ectopic pregnancy, with subsequent perforation and hemorrhage, has been reported over forty times in the 246 cases we have reviewed.

SUMMARY

Two cases of bicornate uteri verified by laparotomy in which pregnancies and spontaneous deliveries have occurred. In the first case a spontaneous abortion had occurred, and in the second an ectopic tubal gestation had ruptured.

The literature has been briefly reviewed and 246 cases have been noted since 1922.

Wassermann Fastness.—The term "Wassermann fastness" has become popular because it apparently is an easy means of explaining to a patient why the blood test remains positive, at the same time being consoling to the physician. This is an unfortunate situation, because a Wassermann fastness is not a diagnosis, but merely an accumulation of serologic reports.

The significant point about Wassermann fastness is that it may occur in any manifestation of syphilis, and it may have much significance or it may be of no concern at all. For example, Wassermann fastness in a patient with early syphilis who has been well treated suggests that there is an active focus of syphilis somewhere, in either the nervous or the cardiovascular system, and that effort should be made to demonstrate it and treat it accordingly. Likewise, a persistently positive Wassermann reaction in association with a positive spinal fluid is indicative of a resistant type of infection in the nervous system. On the other hand, if a diagnosis of latency is warranted, and is confirmed by repeated examinations during the prolonged treatment course, may have no significance. The positive test does not necessarily mean that the syphilis is active or that the patient is infectious.—Queries, *Journal of the American Medical Association.*